State of Tennessee
Department of Finance and Administration
Office of Health Services
706 Church Street
5th Floor Doctor's Building
Nashville, TN 37247-0492

May 29, 2002

Mr. Dennis Smith, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-26-22
Baltimore, Maryland 21244-1850

Dear Mr. Smith:

Thank you for all of the assistance that you and your staff have provided to us during these last few weeks as we have tried to reach final resolution on Tennessee's budget neutrality and other design aspects of the new TennCare waiver. We hope that this letter will provide the necessary clarification on items raised by your staff and will allow us to gain final approval of our new design.

Page 13 - TennCare Medicaid - Enrollment and Disenrollment

- Attachment 1 identifies Tennessee's major Medicaid eligibility categories and the frequency of recertification for each group.

Page 14 - TennCare Medicaid - Service Delivery

- In the February 12, 2002 document, the TennCare Select plan is referred to being "state owned". The TennCare Select plan is operated by a private health maintenance organization under contract with TennCare. The State maintains full financial risk for medical services provided to enrollees in the TennCare Select plan.

Page 17 - TennCare Standard - Eligiblity

- Since the submission of the waiver modification document, there have been changes in the process described for medical eligibility. There are three options that an applicant may use to apply for medical eligibility. All of the processes begin with an eligibility determination at the local Department of Human Services. Anyone who

does not qualify for Medicaid and who meets all of the technical requirements for TennCare Standard uninsured status except for income, will be given an opportunity to apply as medically eligible by completing a special application for medical eligibility. If the application is during a period of closed enrollment, only applicants whose family income is less than 100% of poverty will be allowed to enroll. The medical eligibility application can be completed in one of three ways:

1. The applicant can have his/her physician complete a section of the application by marking any of the qualifying conditions that the applicant has and signing an attestation to that fact. The applicant must submit, along with the completed application, the appropriate medical records to support that attestation. Attachment 2 provides a draft listing of the diseases/conditions that will be used to determine medical eligibility. The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring or treatment. Due to the serious nature of these diseases/conditions most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

2. The applicant can supply TennCare with a declination letter from an underwriting department or authorized agent of an insurance company licensed and authorized to sell individual or association group health insurance policies in the State of Tennessee. Along with the declination letter, which must be dated within the past two months, the applicant must provide a copy of the actual application for health insurance which include medical/physical conditions and the medical records to substantiate the medical reason for the declination of coverage.

3. The applicant can be assessed for SPMI or SED. If the individual is assessed as meeting criteria for CRG Levels 1, 2, or 3, or TPG 2, he/she can provide physician attestation of the diagnosis that supports the basis for the CRG/TPG assessment and the medical records to support that diagnosis.

Each of the methods above requires the applicant to include with the completed application, all supporting documentation, and a $25 non-refundable application fee. Only complete applications accompanied by the required supporting documentation and application fee will be processed. An independent contractor using medical professionals, underwriters, or staff supervised by medical professionals or underwriters will review the applications and supporting medical records to verify medical eligibility.

During a period of closed enrollment, eligibility for those whose family income is below 100% of poverty and qualify as medically eligible will begin on the authorization date or the date that the final eligibility determination is made. (This is a change from the original submission.) During an open enrollment period,

individuals, qualifying for medical eligibility, whose family income is equal to or greater that 100% of poverty, will have prospective coverage beginning the date announced with the open enrollment period.

Medically eligible TennCare Standard enrollees must recertify eligibility on the same schedule as other TennCare Standard enrollees. However, medical eligibility will not be verified annually for those who remain on the program without a break in coverage. The $25 application fee must be paid each time an individual is having medical eligibility verified.

- The TennCare Bureau will provide a written request to CMS for approval to implement any increase in premiums.

- Individuals who were eligible for Medicare, enrolled in TennCare as an uninsured/uninsurable as of December 31, 2001, and do not qualify for Medicaid will be allowed to remain in TennCare Standard for pharmacy benefits only, regardless of income level. These individuals must be "uninsurable" and unable to purchase Medicare supplemental insurance because of a pre-existing medical condition. For non-Medicaid individuals who had Medicare and TennCare as of December 31, 2001, and have not yet been required to prove "uninsurability", a declination letter for a supplemental policy will be required during the recerification period occurring between July 1, 2001, and December 31, 2001. Failure to provide this "proof" of uninsurability will result in disenrollment from the program.

  Individuals who qualify to be "grandfathered" for the TennCare Standard pharmacy benefit will be charged premiums according to the following schedule:

Poverty Level	0% - 100%	101%-149%	150%-199%	200% - 249%	250% - 299%	300% - 349%	350% - 399%	400% - 499%	500% - 599%	Over 600%
Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00	$200.00	$250.00	$350.00	$450.00	$550.00

These premiums will be considered supplemental premiums and will be in addition to any family premiums paid for other TennCare Standard family enrollees. Copayments for pharmacy services will be consistent with the copayments for other TennCare Standard enrollees.

Page 19 - TennCare Standard - Enrollment and Disenrollment

- At this time the State intends to offer continuous enrollment to medically eligible individuals who have family incomes that are less than 100% of poverty. In the event that the State wants to discontinue this practice, thirty-day advance notification will be provided to CMS.

Page 20 - TennCare Standard - Enrollment and Disenrollment

- For the new waiver design transition period, July 1, 2002 through December 31, 2003, individuals who are enrolled in TennCare Standard will receive a six-month eligibility period, assuming that they continue to comply with all program requirements. Because of the transition and the issues revolving around a new eligibility process and enrollment system, some individuals who are recertified during the first six months, July 1, 2002 through December 31, 2002, may be given an eligibility end date that exceeds six months. It would never be greater than twelve months. Any new applications or re-establishment of eligibility made during CY 2003, will include a twelve month eligibility period. Twelve months would be used as the eligibility period in years following the transition period.

  We are seeking authority to allow TennCare to discontinue coverage for TennCare Standard enrollees who have not re-established eligibility by the end date of their enrollment period. Enrollees will be notified at the time of their enrollment and reminded approximately 60 days before the end of the period of the need to complete the re-establishment of eligibility process before the end of their enrollment period. An appeal would still be permitted if an individual is denied eligibility and believes the denial was incorrect. These modifications are consistent with our goal of making the TennCare Standard program mirror commercial health insurance programs.

Page 23 - Other Program Design Features - Special Hospital Payments

- It is our understanding that we would need to request CMS approval to make any supplemental hospital payments in excess of the $100 million payment specifically identified in the waiver document.

Page 33 - Attachment A Summary of Physical Health Benefits and Attachment B Summary of Behavioral Health Benefits

- The annual out-of-pocket maximums for TennCare Medicaid pharmacy copays are $360 per individual.

- The annual out-of-pocket maximums for TennCare Standard copays are as follows:

100% - 199% of poverty	$1,000 individual; $2,000 family
200% of poverty and above	$2,000 individual; $4,000 family

Other Changes or Clarifications

- Simultaneous to our discussions with CMS about the new TennCare program design and budget neutrality for the new waiver, the State has been trying to identify strategies to deal with the "runaway" trends in pharmacy expenditures. One strategy

that has been developed and represents a change to our original submission is the requirement that TennCare Medicaid and TennCare Standard enrollees share in the cost of pharmaceuticals through pharmacy copayments. On January 1, 2003, TennCare plans to implement a sliding scale system of three-tiered copays for pharmacy services. Our actuarial consultants indicate that the implementation of pharmacy copays will result in both decreases in pharmacy utilization and reductions in pharmacy costs.

TennCare will implement three triple-tiered copays for both the TennCare Medicaid and TennCare Standard programs. Enrollees receiving pharmacy benefits for behavioral health drugs and dually eligible enrollees will also have pharmacy copay requirements through those two pharmacy carve-outs. The different triple-tiered copays will be based on both eligibility categories and income levels. Attachment 3 provides additional information on this new design feature.

We are seeking authority to permit providers to deny pharmacy services to TennCare Standard enrollees who do not make pharmacy copayments.

- New TennCare Medicaid and TennCare Standard enrollees will be allowed to choose their MCO at the time that they apply for TennCare coverage. Once they are notified of their TennCare enrollment, they will have 45 days to change to another available MCO within their geographic area. The opportunity for a choice at the time of enrollment will not exist for SSI enrollees whose eligibility is determined at the Social Security Administration office. These enrollees will be assigned to an MCO and will have the same opportunity to change within 45 days.

  TennCare Medicaid and TennCare Standard enrollees enrolled as of July 1, 2002 will be given an opportunity to change their MCO only during their first recertification of eligibility during CY 2003 and annually thereafter. A ballot process for TennCare Medicaid SSI enrollees will be held in the Spring of 2003 and annually thereafter unless a similar process for allowing choice at the time of recertification can be developed with the Social Security Administration.

  After the 45 day period ends, TennCare Standard enrollees will not be afforded an opportunity to change to another MCO until their next recertification (in other words, there will be no good cause exception). For this reason, we intend to seek a modification of the Grier decree to the extent it requires us to treat all requests for a change in MCO through the grievance appeal process. This change will further our goal of making TennCare Standard like a commercial insurance program.

- Individuals who are both Medicaid and Medicare eligible will not be included in the 1115 demonstration program. It is our intent to serve these enrollees through a 1915 waiver. It is our understanding that CMS will work with the State to gain that authority prior to July 1, 2002.

We will, in the very near future, be working with you to identify opportunities for Tennessee to participate in the SCHIP program. We are anxious for the opportunity to access Tennessee's SCHIP allotment since Tennessee has been and continues to be one of the leaders in providing health care coverage to children.

If you have any questions, please feel free to contact me at (615) 532-0492. We look forward to continuing our work with you as we move into the next phase of Tennessee's successful health care program.

Sincerely,

John Tighe
Deputy to the Governor for Health Policy

Cc: Mike Fiore
Rose Hatten
Joe Millstone

Attachment 1

Major Medicaid Eligibility Categories in Tennessee
May 2002

Medicaid Category	Income Limit	Resource Limit	Frequency of Recertifications
Persons receiving SSI	$531 for 1 person	$2000(1) $3000(2)	According to federal review procedures*
Qualified pregnant women and infants to age 1	185% poverty	None	Pregnant women are eligible through their pregnancy and for 2 months postpartum; newborns are not recertified until their first birthday; other infants who come into the program after the newborn period are recertified every 6 months
Qualified children from age 1 to age 6	133% poverty	None	Every 6 months
Qualified children from age 6 to age 19 (birthdays must be after 9/30/83)	100% poverty	None	Every 6 months
Families First (TANF)	$830 for a family of 3	$2000(1) $3000(2)	Every 6 months**
Medically Needy children, caretaker relatives, aged, blind, and disabled	"Spend down" to $317 per month for a family of 3	$2000(1) $3000(2)	Children and caretaker relatives are reviewed every 6 months; other adults are reviewed annually
Individuals requiring care in an ICF/MR	300% of the SSI benefit rate	$2000(1) $3000(2)	Annually
Individuals requiring care in a NF	300% of the SSI benefit rate	$2000(1) $3000(2)	Annually
Individuals who but for the provision of HCBS services would be eligible for Medicaid in an ICF/MR or NF	300% of the SSI benefit rate	$2000(1) $3000(2)	Annually
Children in special living arrangements	$418 for a child from birth to 2	$2000(1)	Every 6 months
Individuals under age 21 in adoptions subsidized in full or in part by a public agency	$418 for a child from birth to 2	$1000(1)	Every 6 months
Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level	300% of the SSI benefit rate	$2000(1) $3000(2)	Annually

*In Tennessee, because of the *Daniels* lawsuit, persons who lose SSI coverage are not terminated from the Medicaid rolls. They continue on as Medicaid eligibles.

**Tennessee has a TANF waiver which allows Transitional Medicaid (TM) to be available for 18 months after TANF benefits end. TM continues throughout the 18-month period without additional recertification unless the recipient either moves out of state or dies. TennCare recognizes the TM period which is approved for the state's TANF waiver and will continue TennCare coverage throughout the TM period.

Attachment 2

DRAFT - May 28, 2002 - Proposed Disease Listing:

Disease/Condition	Corresponding ICD-9 Code(s)
ALS	335.20
Cancer**, with active treatment in past 12 months (includes Hodgkin's Disease, leukemia, lymphoblastoma, lymphoma, malignant tumor, melanoma, sarcoma)**	140-149,150-159,160-165, 170-172, 174-176, 179-189, 190-197, 198-199, 200-208
Cystic Fibrosis	277.0
Diabetes**, Type 1, with comorbidity; Juvenile Diabetes**	250.1-250.9
Coagulation Defects **(Hemophilias, Christmas Disease, and other clotting factor disorders)**	286.0-286.9
HIV/AIDS	136.3, 176.0-176.9
Huntington's Chorea	333.4
Hydrocephalus	742.3
Kidney Failure**, with dialysis**	584-586
Multiple Sclerosis	340
Muscular Dystrophies	359.0, 359.1, 359.2 and 359.3
Organ Transplant	Cornea, V42.5 Heart, V42.1 Heart Valve, V42.2, V43.3 Kidney, V42.0 Lung, V42.6 Liver, V42.7 Bone Marrow, V42.81 Pancreas, V42.83 Intestines, V42.84
Psychotic Disorders (**including Schizophrenia)**	296.9, 297, 298, 299
Quadriplegia	344.00-344.09
Sickle Cell Disease	282.60, 282.62, 282.63, 282.69
Still's Disease	714.30
Thalassemia Major	282.4
Traumatic Brain Injury	850.4
Alzheimer's	290-290.21
Asbestosis	501
Cardiomyopathy	425
Cerebral Palsy	343
Chronic Pancreatitis	577.0
Cirrhosis of the Liver	571.5
Congestive Heart Failure	428
Crohn's Disease	555.9
Epilepsy	345.9
Heart Valve Replacement	V42.2
Hepatitis C	070.41, 070.44, 070.51, 070.44
Open Heart Surgery	CPT Codes, 33517-33530 and 33533-33545, 33572, 33510-33516
Arrhythmias	426, 427
Bipolar Disorders	296
Cardiac Pacemakers	V45.0
Cerebrovascular Accidents (Thrombosis/Hemorrhage)	430, 431, 432, 433.0-433.9, 434, 436

Chronic Obstructive Pulmonary Disease	496, 491.2, 492
Chronic Pancreatitis	577.1
Congenital Heart Disease	745 , 746 , 747.0-747.49
Coronary Artery Disease (Myocardial Infarctions, Open Heart Surgery)	410, 411, 412, 413, 414
Demyelinating Diseases	340, 341
Esophageal Varicies	456.0, 456.1, 456.2
Friedreich's Ataxia***	334.0
Hamman-Rich Disease	516.3
Lead Poisoning	961.2, 984
Marfan's Syndrome	759.82
Myasthenia Gravis	358.0
Neimann-Pick Syndrome	272.7
Neurofibromatosis	237.70, 237.71, 237.72
Osteogenesis Imperfecta	756.51
Parkinson's Disease	332, 333.0
Phenylketonuria (PKU)	270.1
Polyarteritis Nodosa	446.0
Polycystic Renal Disease	753.12-753.14
Rheumatic Heart Disease	391, 392, 393, 394, 395, 396, 397, 398
Rheumatiod Arthritis	714.0-714.89
Scleroderma	710.1
Syringomyelia	336.0
Systemic Lupus Erythematosis	710.0
Tuberculosis	011, 012, 013, 014, 015, 016, 017, 018
Ulcerative Colitis	556
Wilson's Disease	275.1

Attachment 3

TennCare Pharmacy Copayments

TennCare Medicaid

TennCare Medicaid enrollees will be assigned to a managed care organization (MCO) that will be responsible for collecting pharmacy copays through their pharmacy providers. Online, point-of-service pharmacy claims processing systems will recognize Medicaid eligibility when a pharmacy claim is submitted and reduce the reimbursement to the pharmacist by the appropriate copay amount. The State's behavioral health pharmacy claims processor will perform the same processing for behavioral health drugs. The dispensing pharmacist will collect the appropriate copayment from the enrollee. TennCare Medicaid enrollees will be required to pay one of three different copay amounts for each prescription:

Generic, multisource drugs	$1.00
Brand name, single source drugs	$1.00
Brand name, multisource drugs	$3.00

Brand name, single source drugs are drugs for which the patent has not expired and therefore do not have a generic equivalent available. Brand name, multisource drugs are drugs for which the patent has expired and generic equivalents are available. This copay structure is designed to increase generic utilization and decrease inappropriate utilization with corresponding reductions in total pharmacy costs. Pharmacy copayments will not be required for TennCare Medicaid enrollees who are children or long term care residents. Pharmacy copayments will not be required for pregnancy related services or supplies, in emergency situations or for family planning products prescribed for TennCare Medicaid enrollees.

TennCare Standard

TennCare Standard enrollees will be required to pay pharmacy copays at the point-of-service, based on their income level. TennCare Standard enrollees will be required to make copayments for each prescription as described below. The same copay schedule applies to non-Medicaid/ Medicare duals who are enrolled in TennCare Standard for the pharmacy benefits.

TennCare Standard enrollees whose family income is *below* 100% of poverty pay:

Generic, multisource drugs	$1.00
Brand name, single source drugs	$3.00
Brand name, multisource drugs	$5.00

TennCare Standard enrollees whose family income is *above* 100% of poverty pay:

Generic, multisource drugs	$5.00
Brand name, single source drugs	$15.00
Brand name, multisource drugs	$25.00

TennCare Maintenance Drug List

TennCare will develop and publish a list of generic, multisource drugs used in the maintenance of chronic conditions that may be dispensed in quantities of one hundred (100) units or a three-month supply, whichever is greater. This maintenance drug list will allow dispensing pharmacies to provide greater supplies of chronic medications to members and reduce copayments for enrollees with appropriate, yet high utilization needs.

Maximum Out-of-Pocket Copayment Limits

The maximum out-of-pocket pharmacy copayment responsibility for any TennCare Medicaid enrollee will be thirty ($30) dollars per calendar month and for any TennCare Standard enrollee will be one hundred fifty ($150) dollars per calendar month. The online, point-of-service pharmacy claims processing systems will calculate monthly copayments for each enrollee and not require further copayments from any enrollee whose out-of-pocket expenditures for pharmacy copayments exceeds the applicable maximum out-of -pocket in any given calendar month.

Pharmacy Cost Inflation and Copayments

TennCare will review pharmacy cost and utilization trends annually and may adjust pharmacy copayments each year to compensate for those trends. A request for approval would be submitted to CMS prior to any changes being made.

Marketing by Pharmacy Providers

Pharmacy Providers may not waive pharmacy copayments for TennCare Medicaid or TennCare Standard enrollees as a means of attracting business to their establishment. This does not prohibit a pharmacy from exercising professional judgment in cases where a enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.

Specific Exclusions from Pharmacy Copay Requirements - TennCare Medicaid

Pharmacy copayments will not be required for TennCare Medicaid enrollees who are children or long term care residents. Pharmacy copayments will not be required for pregnancy related services or supplies, in emergency situations or for family planning products prescribed for TennCare Medicaid enrollees..

Pharmacy Copays for 14-day Supplies

The 14-day emergency supply requirements of the Grier Consent Decree do not affect the pharmacy copayment requirements. Every prescription for all enrollees will require a copayment responsibility of the enrollee according to their eligibility category and income level as described above. In the event that the 14-day supply represents less than a full prescription, the copayment will be 50% of the copayment value, allowing for the additional 50% to be charged for the remainder of the prescription.

The 14-day supply requirement has proven to be extremely costly, and has undermined efforts to control the prescription of unnecessarily expensive drugs. In light of the resources available for

the TennCare program we will be seeking modification of the Grier decree to eliminate this requirement and revert to the 72-hour provision in the Medicaid regulations.